

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. Johnson

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-A

08411

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

Wicomico

County

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wicomico General Hospital

3 weeks

How long in hospital or institution?

## 3. (a) FULL NAME

Adkins Mr. Russell Taylor

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

White Mrs. Anna

7. Birth date of deceased (mo., day, yr.)

Aug. 14-1896

6. (c) If alive, give age

54

years

8. AGE:

Years

Months

Days

If less than one day

50

0

3

hrs. min.

9. Birthplace

Wicomico County Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

David Henry Adkins

MOTHER FATHER

Name

12. Name

Pondville Md.

13. Birthplace

Sarah Margaret Taylor

14. Maiden name

R.D. Quadratic Md.

15. Birthplace

Mrs. Anna B. Adkins

16. Informant

R.D. Mandala Md.

Address

Burial

Date thereof

Aug. 19-1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mandala Cemetery

Location

Wicomico

G. Walter Jr.

Follett

Address

Salisbury Md.

19. 8/19/46

(Date rec'd by registrar)

19. 8/19/46

Classified by

Social

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

City or town

Mandala

Street No.

R.D.

County

Wicomico

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946, at 7A.

21. VERIFY that death occurred on the date above stated; that I attended deceased from

July 28 1946, to August 17 1946

and that I last saw him alive on August 17 1946

Immediate cause of death Myocarditis with renal failure

Symptoms 6 months

Due to Chronic (essential) hypertension

Symptoms 3 years

Due to

Other conditions Hypertensive Heart Disease &amp; Hemorrhagic colitis

(Include pregnancy within 3 months of death)

## Major findings of operations

Autopsy results Hemorrhage into bowel structure &amp; necrosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where)

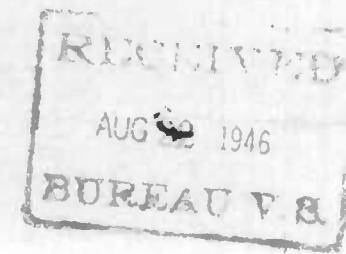
Means of injury Injured at work

## 23. SIGNATURE

M. D. or other

Address 307 N. Division St. Date signed 8/17/46

Salisbury, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (464)

08412

## CERTIFICATE OF DEATH

Reg. Dist. No. 330

## 1. PLACE OF DEATH:

County

Mardela Md R.D.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

22 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Linda M. Bradley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

white

Married

Louis E. Bradley

6. (b) Name of husband or wife

8. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.)

Oct 14 1874

8. AGE: Years

Months

Days

If less than one day

71

9

20

hrs.

min.

9. Birthplace

Bedford Sussex, Del

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

John Robinson

FATHER

12. Name

John Robinson

MOTHER

13. Birthplace

Md.

14. Maiden name

Unknown

15. Birthplace

Md.

16. Informant

Louis E. Bradley

Address

Mardela Md R.D.

17. Burial

Date thereof

8 6 1946  
(month) (day) (year)

(Burial, cremation, or removal - Where?)

Cemetery or crematory

Mardela Md

Location

Mardela Md

18. Funeral director

Grovernor Bros

Address

Sharptown Md.

19. (Date record by registrar)

19

W.H. Robertson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Md.

City or town

Mardela Md R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 3<sup>rd</sup> 1946 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1<sup>st</sup> 1946 to Aug 3<sup>rd</sup> 1946and that I last saw her alive on Aug 3<sup>rd</sup> 1946

1946

Immediate cause of death

Carcinoma of Throat

Due to

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

William Emeric

H. Elmer Md

Date signed Aug 4-46

RECEIVED

AUG 10 1946

BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

08413

## CERTIFICATE OF DEATH

Reg. Dist. No. 334

1. PLACE OF DEATH: Hieronimo  
 County Mardela City or town MD RD  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary E. Bradley

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife William F. Bradley

7. Birth date of deceased (mo., day, yr.) June 2 1862 6. (c) If alive, give age years

8. AGE: Years 84 Months 2 Days 0 It less than one day hrs. 0 min. 0

9. Birthplace Riverton Stic Md  
 (Town, county, and state)

10. Usual occupation House work

## 11. Industry or business

12. Name Joseph Taylor  
 13. Birthplace St. Louis Mo.

14. Maiden name Elizabeth Bennett  
 15. Birthplace St. Louis Mo.

16. Informant Mrs. Mack Beckerson  
 Address Mardela MD RD

17. Burial Burial Date thereof 8 20 1946  
 (Burial, cremation, or removal (which)) Date thereof (month) (day) (year)

Cemetery or crematory Riverton  
 Location Riverton Md

18. Funeral director Gravemor Bros  
 Address Charlottesville MD

19. 8/20/46 19 W.H. Robertson  
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State MD County St. Mary  
 City or town Mardela MD RD  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.  (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1946 st 2809 M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1946 Aug 18 1946  
 and that I last saw her alive on Aug 17 1946

Immediate cause of death

Carcinoma Breast DURATION 6 months

Due to

Due to

Other conditions Cerebral Hemorrhage DURATION 9 months

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

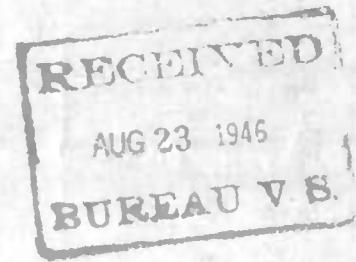
Means of injury

Injured at work?

23. SIGNATURE J.S. Kicklighter, M.D.

M. D. or other

Address Charlottesville Date signed 8/19/46



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore <sup>Ma</sup>

08414

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Pittsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 84 yrs.Hospital, institution, or street address where death occurred How long in hospital or institution? ✓

## 3. (a) FULL NAME

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Lorenzo Brittingham7. Birth date of deceased (mo., day, yr.) Dec 21, 18608. (c) If alive, give age 84 years8. AGE: Years 84 Months 3 Days 28 If less than one day hrs.  min. 9. Birthplace Pittsville

(Town, county, and state)

10. Usual occupation Blawork11. Industry or business FATHER 12. Name Josephus N. Nelson13. Birthplace Md.MOTHER 14. Maiden name Julia Gorlow15. Birthplace Md.16. Informant Mrs. Paul BakerAddress Berlin, Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof Aug 21, 1946

(month) (day) (year)

Cemetery or crematory Gorlow's CemeteryLocation Pittsville, Md.18. Funeral director M. Pasha WatsonAddress Selegville, Md.19. 8/28/46 (Date rec'd by registrar) Harriet J. Johnson (Signature)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Pittsville (If outside city or town limits, write RURAL and give nearest town)Street No. no street (If rural, give LOCATION)2.(a) If veteran, name war 3. (b) Social Security Number 333-10-1234

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1 1946 to Aug 19 1946and that I last saw her alive on Aug 19 1946 dead on Aug 19 1946Immediate cause of death Cardiovascular DiseaseDURATION 1946Due to Due to Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings or operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State) Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Y. J. Lewis Jr. M. D. or other Address Wellsboro, Md. Date signed 8/28/46

WIRE TO THE UNITED STATES GOVERNMENT

RECEIVED IN 1945

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AUG 24 1945

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 40

## CERTIFICATE OF DEATH

08415

Reg. Dist. No. 393

## 1. PLACE OF DEATH

County

Wicomico  
Paramount

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

7. Birth date of  
deceased (mo., day, yr.)

5. (c) If alive, give age

years

Sept 9 1871

8. AGE:

Years

Months

Days

If less than one day

hr.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal (which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

R.D.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Aug. 23 1968 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw h. medical exam. on 19 to 19

Immediate cause of death

cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

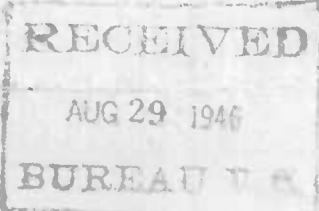
23. SIGNATURE

Sergeant Medical Examiner

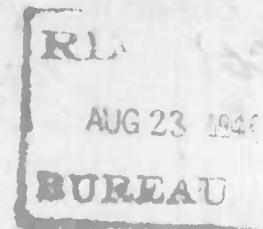
M. D. or other

Address

Date signed 8/26/68







Evidence for the change of age is shown on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

08417

FILM No. 108 OCT 28 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

## 1. PLACE OF DEATH:

County Wicomico  
City or town Nanticoke  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Caroline Douglas

4. Sex

F

5. Color or race

white

6. (a) Single, married, widowed, or divorced

WidowedLafayette Douglas

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 8, 1864

8. AGE:

82

Years

81

Months

10

Days

19

If less than one day

hrs.

min.

9. Birthplace

Nanticoke, Wicomico, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Edward Travers

MOTHER FATHER

12. Name Edward Travers

13. Birthplace

Nanticoke, Md.

14. Maiden name

Margaret Messick

15. Birthplace

Nanticoke, Md.

16. Informant

Stella Welling

Address

Nanticoke, Md.

17. Burial

Date thereof 8/29/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Cemetery, (Turners)

Location

Nanticoke, Md.

18. Funeral director

C. G. Messick

Address

Baltimore, Md.

19. Date rec'd by registrar

Aug. 28, 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County WicomicoCity or town Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1946 at 10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 26 1946 to 1946and that I last saw her alive on Aug. 26 1946

Immediate cause of death

Osteosclerotic Cerebral Arteriosclerosis

DURATION

?Due to Carcinoma of breast4 year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

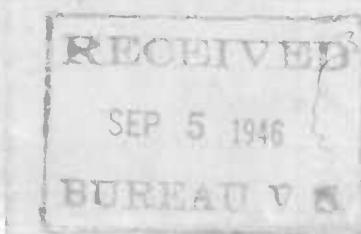
23. SIGNATURE

Robert J. Soreno

M. D. or other

Address

Nanticoke, Md.Date signed 8-27-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 110

08418

## CERTIFICATE OF DEATH

Reg. Dist. No. 393

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 Years

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 15 Min.

## 3. (a) FULL NAME

William S. Dykes

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Susie L. Dykes6. (c) If alive, give age 51 years7. Birth date of deceased (mo., day, yr.) May 17, 18918. AGE: 55 Years 2 Months 23 Days If less than one day hrs. min.9. Birthplace Salisbury, Wicomico, Co. Md. (Town, county, and state)10. Usual occupation Salesman11. Industry or business Wholesale Groceries12. Name Stanbury W. Dykes13. Birthplace Wicomico, Co. Md14. Maiden name Elvina Brown15. Birthplace Wicomico, Co. Md16. Informant Richard W. DykesAddress Salisbury, Md17. Burial Parsons Cemetery Date thereof Aug. 12, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Parsons CemeteryLocation Salisbury, Md18. Funeral director The Hill & Johnson Co.Address Salisbury, Md19. 8/15/46 (Date read by registrar) 19... Registrars Initials Harriet E. Johnson  
Address Salisbury, Md

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... WicomicoCity or town... Salisbury (If outside city or town limits, write RURAL and give nearest town)Street No... 125 W. Locust St. (If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 1946 19... 1946 DURATION 115 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 8, 1946 to Aug. 9, 1946 and that I last saw him alive on Aug. 8, 1946 Aug. 9, 1946

Immediate cause of death

coronary thrombosis abr 12

Due to

Due to

Hypertension Chronic nephritis { 10 to 12 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

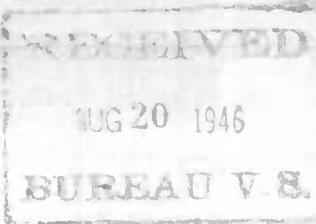
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE John R. Mann M. D. or otherAddress Salisbury, Md Date signed 8/12/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8

08419

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

415. Sans St.

How long in hospital or institution?

## 3. (a) FULL NAME

Edwin Shays Fitch

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

## 6. (b) Name of husband or wife

Amanda Sarah Fitch

7. Birth date of deceased (mo., day, yr.)

June 3<sup>rd</sup> 1893

8. (c) If alive, give age 48 years

8. AGE:

Years 53 Months 2 Days 13 If less than one day hrs. min.

## 9. Birthplace

Philadelphia Pa

(Town, county, and state)

## 10. Usual occupation

Sarah &amp; Servt year

## 11. Industry or business

## 12. Name

no Record Fitch

## 13. Birthplace

Philadelphia Pa

## 14. Maiden name

no Record

## 15. Birthplace

Philadelphia Pa

## 16. Informant

Mrs. Carolina Brandt

## Address

1605 Green St. Phila. Pa

## 17. Buried

(Burial, cremation, or removal. Which?)

Date hereof Aug 23 1946

## Cemetery or crematory

(month) (day) (year)

## Location

Parson's Cemetery

## Holloway &amp; Co.

Salisbury Maryland

## 18. Funeral director

Walter R. Holloway

## 19. (Date rec'd by registrar)

Salisbury Maryland

## 19. (Date rec'd by registrar)

8/23/46 Harriet S. Johnson

## Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

City or town

Salisbury

County

Street No.

415.

County

## 2.(a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Aug. 16<sup>th</sup> 1946 at 11:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 1946 to August 14 1946

and that I last saw him alive on August 14 1946

## Immediate cause of death

Respiratory Failure

## DURATION

1 day

Due to Progressive Bulbar

## 2?

## Due to

Other conditions (Freudreich Syndrome)

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

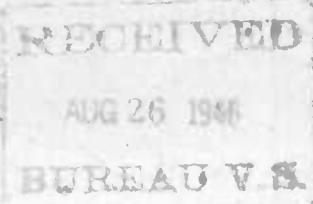
Robert J. Fitch

M. D. or other

Address

Salisbury, Md.

Date signed 8/23/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12270

08420

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 daysHospital, institution, or street address where death occurred: D. S. HospitalHow long in hospital or institution? 15 days

## 3. (a) FULL NAME

Rosa Bell Gaddy

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F col Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 4, 1916

8. (c) If alive, give age

years

8. AGE: Years 30 Months 4 Days 19 If less than one day

hrs. min.

9. Birthplace Wadesboro, N. C.

(Town, county, and state)

10. Usual occupation Labored

## 11. Industry or business

12. Name George Gaddy13. Birthplace Wadesboro, N. C.14. Maiden name Lonie Biles15. Birthplace Wadesboro, N. C.16. Informant George GaddyAddress 1227 Gholston St, Winston-Salem17. Burial Date thereof 8/27/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Evergreen CemeteryLocation Winston-Salem, N. C.18. Funeral director E. G. MessickAddress Baltimore, Md.19. 8/27/46 (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County WicomicoCity or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1946, at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 18 1946 to Aug 23 1946and that I last saw her alive on Aug 22 1946

## Immediate cause of death

Intestinal obstruction DURATION 3 daysAcute appendicitis. DURATION 2 mmo

Due to...

## Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations gangrene of intestine  
adhesions, & obstruction Date of op. 8/23/46

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

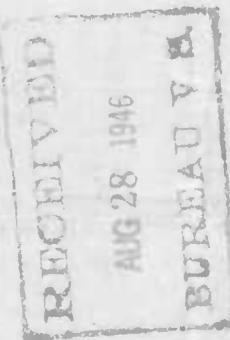
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. RodenbakerM. D. or other JohnsonAddress Salisbury, Md. Date signed 8/27/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

08421

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County... MarylandCity or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One day - 11 hrs. 44 mins.

Hospital, Institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? One day - 11 hrs. 44 mins.

## 3. (a) FULL NAME

Stobbs, Baby Boy (Twin 1)

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

## 6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Aug. 16 - 1946

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name

Martin C. Stobbs

13. Birthplace

Princess Anne Md

14. Maiden name

Alma Dryden

15. Birthplace

Princess Anne Md

16. Informant

Mrs. Martin C. Stobbs

Address

Vienna Maryland

17. Burial

(Burial, cremation, or removals which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Waco. Mem Park

Location

Salisbury Md

18. Funeral director

Walter R. Johnson

Address

Salisbury Maryland

19. (Date read by registrar)

8/19/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MDCounty... OxfordCity or town... Mearns

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1946 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 16 1946 to Aug. 17 1946and that I last saw him alive on August 17 1946

Immediate cause of death

Respiratory failuredue toPrematurity

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

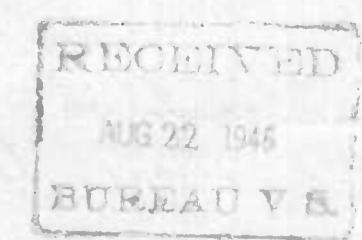
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address... Robert R. StarrDate signed 8-18-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170

08422

## CERTIFICATE OF DEATH

Reg. Dist. No. 393

## 1. PLACE OF DEATH:

County..... WicomicoCity or town..... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 years

Hospital, Institution, or street address where death occurred:

..... Peninsula General HospitalHow long in hospital or institution?..... 7 days

## 3. (a) FULL NAME

William J. Goodwin

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... not available

8. AGE:	Years	Months	Days	If less than one day
	51			hrs. ..... min.

9. Birthplace..... not available  
(Town, county, and state)

10. Usual occupation.....

## 11. Industry or business

12. Name	not available
13. Birthplace	

14. Maiden name	not available
15. Birthplace	

16. Informant.....

Address

17. Burial..... Parsons Cemetery Date thereof. Aug. 19, 1946  
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory..... Parsons CemeteryLocation..... Salisbury, Md18. Funeral director..... The Hill & Johnson Co.Address..... Salisbury, Md19. 8/26/46 (Date rec'd by registrar) Marceline Johnson (Signature of Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... WicomicoCity or town..... Powellville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 10, 1946 19..... 48A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Medical Examiner 19..... 48A M

## Immediate cause of death

Fractional  
Skull - Brain injury

Due to.....

Due to.....

Other conditions..... None

(Include pregnancy within 8 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of..... 8/3/46Where did injury occur? New Anthony (City or town) (County) Wicomico (State) MdInjured at home, farm, industry, public place (where?) HighwayMeans of injury Fell off truck Injured at work? No23. SIGNATURE..... Deputy Md. Coroner M. D. or otherAddress..... Salisbury, Md Date signed 8/13/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

08423

## CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH: *Mardela*

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex: *Male* 5. Color or race: *White* 6. (a) Single, married, widowed, or divorced: *Married*6. (b) Name of husband or wife: *Ruth Estelle Gray*7. Birth date of deceased (mo. day, yr.): *June 24-1910* 6. (c) If alive, give age: *27* years8. AGE: *36* Years *1* Months *12* Days If less than one day *hrs.* *min.*9. Birthplace: *Brooklyn, New York* (Town, County, and state)10. Usual occupation: *Champer*11. Industry or business: *Taxi Driver*12. Name: *Robert Gray*13. Birthplace: *Ireland*14. Maiden name: *Mellie Flemming*15. Birthplace: *Ireland*16. Informant: *Mrs. Ruth Estelle Gray*Address: *Bridge St. Mardela*17. Burial: *Burial* Date thereof: *Aug. 8th 1946* (Burial, cremation, or removal, which?)Cemetery or crematory: *Mardela*Location: *Mardela, Maryland*18. Funeral director: *W. H. Robertson*Address: *Salisbury, Maryland*19. Date rec'd by registrar: *8/8/46* 19.....(Date rec'd by registrar) *W. H. Robertson* Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

Rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *Aug. 6th 1946* at *3:30 PM*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug. 4th* to *Aug. 6th* 1946and that I last saw him alive on *Aug. 6th* 1946Immediate cause of death: *Adult Cardiac**Failure*Due to *Hypertension* *Cardio* *Impulse* *Failure* *10 AM*Due to *Obstruction* *Failure* *10 AM*Other conditions: *Obstruction* *Failure* *10 AM*

(Include pregnancy within 3 months of death)

## Major findings or operations.....

Date of op. ....

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

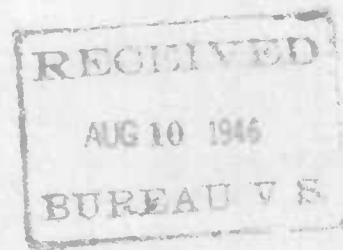
## Means of injury.....

Injured at work? .....

23. SIGNATURE: *J. H. Lynch*

M. D. or other

Address: *Arbutus, Md.* Date signed: *Aug. 11/46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 188

08424

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Salisbury

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

## 3. (a) FULL NAME

Adineal Griffin

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced unknown

male a. a. unknown

6. (b) Name of husband or wife unknown

7. Birth date of deceased (mo., day, yr.) about 1906 8. (c) If alive, give age about years

8. AGE: Years about Months — Days — If less than one day — hrs. — min. —

9. Birthplace unknown (Town, county, and state)

10. Usual occupation Don't know

11. Industry or business Same as above

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant none

Address none

17. Burial Burial (Burial, cremation, or removal. Which?) Date thereof Aug 14-46 (month) (day) (year)

Cemetery or crematory Public

Location Salisbury (Md)

18. Funeral director James P. Stewart

Address Salisbury (Md)

19. 8/19/46 (Date record by registrar) 1946 (Year)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war Don't know

## 3. (b) Social Security Number

Don't know

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10<sup>th</sup> 1946 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical 13 to 19 and that I last saw him alive on 8/10/46 Report 19

Immediate cause of death

Drowning Salinity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8/10/46

Where did injury occur? Salinity Wicomico Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) River - washed

Means of injury Ran to edge Police pursuit & fell in river Injured at work? No

23. SIGNATURE Philadelphia 112 Supply Medical Corporation or other

Address Salisbury (Md) Date signed 8/12/46

RECEIVED

AUG 22 1946

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4B-D

## CERTIFICATE OF DEATH

08425

Reg. Dist. No. 393

## 1. PLACE OF DEATH:

County: WashingtonCity or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street, address where death occurred:

Peninsular General HospitalHow long in hospital or institution? 8 days

## 3. (a) FULL NAME

Haley Mrs. Sadie

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white6. (b) Name of husband or wife: Haley Mr. Herbert J.

7. Birth date of deceased (mo., day, yr.)

February 8<sup>th</sup> 1885

6. (c) If alive, give age years

8. AGE:

Years  
61

Months

Day

If less than one day

hrs. min.

9. Birthplace:

(Town, county, and state) Hallwood

10. Usual occupation:

Housewife

11. Industry or business

12. Name: William J. Larkford13. Birthplace: near Hallwood, Va.14. Maiden name: Willie Anna Leader15. Birthplace: Hallwood, Va.16. Informant: Herbert J. HaleyAddress: Hallwood, Va.17. Burial Date thereof: Aug 1 1946  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory: GreenwoodLocation: Temperanceville, Va.18. Funeral director: J. P. Johnson Inc.Address: Parkside, Va.19. 8/7/46 (Date rec'd by registrar)19. 8/7/46 (Date signed)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: AccomackCity or town: Hallwood (If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 5 1946 at 109 M

21. I CERTIFY that death occurred on the day above stated; that I attended deceased from

July 30 1946 to Aug 5 1946and that I last saw him alive on Aug 5 1946

Immediate cause of death:

Arrauma of brain

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations: lungsDate of op. 1/1/46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of:

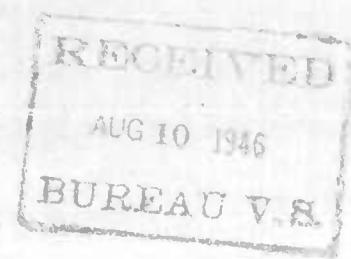
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE: J. P. JohnsonM. D. or other ✓Address: Salisbury Date signed 8/7/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

158

## CERTIFICATE OF DEATH

0842  
Reg. Dist. No. 500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

Wisconsin

City or town.....

Colo. R.F.D. 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 month

Hospital, Institution, or street address where death occurred:.....

No

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male colored Single

8. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Aug. 30, 1946

8. AGE: Years Months Days If less than one day

✓ ✓ ✓ 1 hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

None

## 11. Industry or business

12. Name..... John H. Harris

13. Birthplace..... Georgia

14. Maiden name..... Mabel Harris Brown

15. Birthplace..... Georgia

## 16. Informant.....

John H. Harris

Address..... Colo. R.F.D. 2

17. Burial..... Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date read by registrar).....

19. (Date read by registrar).....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wisconsin

City or town..... Baltimore Colo. R.F.D. 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 31, 1946, at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19. Examiners certificate 19.

Immediate cause of death..... New Born certificate 19.

DURATION..... 1/2 hr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... None Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no Date of.....

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... S. Kademeyer M.D.

M. D. or other.....

Address..... Salisbury, Md. Date signed..... 9/2/46

RECEIVED

SEP 26 1946

BUREAU P.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 36B

## CERTIFICATE OF DEATH

Reg. Dist. No. 08427  
333

1. PLACE OF DEATH:  
 County Wicomico  
 City or town Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital  
 1 hour

How long in hospital or institution?

3. (a) FULL NAME

Addie Holbrook

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Harry Holbrook

7. Birth date of deceased (mo. day. yr.) June 16, 1906 6. (c) If alive, give age 45 years

8. AGE: Years 40 Months 1 Days 25 If less than one day  
 hrs. ..... min. ....

9. Birthplace Wicomico County, Maryland  
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

12. Name Bayard H. Quinton

13. Birthplace Wicomico County, Maryland

14. Maiden name Ardella A. Gosslee

15. Birthplace Wicomico County, Maryland

16. Informant Harry Holbrook

Address Merdele Springs, Maryland, P.T.D.

17. Burial Date thereof August 15 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory San Domingo Cemetery

Location Near Sharptown, Maryland

18. Funeral director J. D. Trampston & Son

Address Federalsburg, Maryland

19. 8/16/46 (Date recd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Merdele Springs Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. San Domingo

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 1946 to Aug 11 1946 and that I last saw her alive on Aug 11 1946

Immediate cause of death Neonavelure, vaginal DURATION 3 days

Due to Infection 10 days

Due to Previous operations for Fistulization of uterus

Other conditions Thrombosis of uterine uterus & vaginal (Include pregnancy with Pneumonitis)

Major findings of operations Fibroid tumors Date of op. 7/26/46

acute salpingitis

Autopsy results Perforation of uterus as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

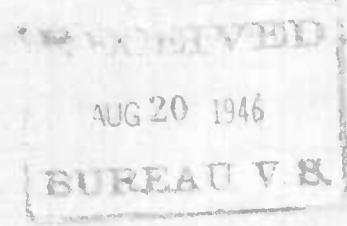
Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

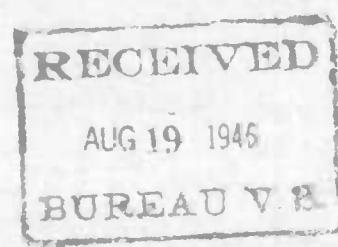
23. SIGNATURE J. D. Rademacher M. D. or other MD

Address Merdele Springs, Maryland Date signed 8/11/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

0842-333  
Reg. Dist. No. 333

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

6. (c) If alive, give age

years

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

Burial

Cremation

Removal

Cemetery or crematory

Location

Funeral Director

Address

Date record'd by registrar

(Date record'd by registrar)

8/27/46

9/6/46

Hassie L. Johnson

Local

Registrar

Address

Sarah E. Hurley

AUG 29 1946

BUREAU F.B.I.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 403

08430

## CERTIFICATE OF DEATH

Reg. Dist. No. 233

## 1. PLACE OF DEATH:

County.....

Wicomico

City or town.....

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 14 days - 17 hrs 45 min

## 3. (a) FULL NAME

Hallie Lester

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

Single.

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, year)

Dec. 9

6. (c) If alive, give age.....years

1901

8. AGE:

Years  
44Months  
8Days  
19If less than one day  
hrs. min.

9. Birthplace.....

Chincoteague Va

(Town, county, and state)

10. Usual occupation.....

Telephone operator

11. Industry or business

12. Name..... John Lester

13. Birthplace..... Chincoteague Va

14. Maiden name..... Adasie Birch

15. Birthplace..... Chincoteague Va

Indiana, Danielle

16. Informant.....

Address Chincoteague Va

17. Burial.....

(Burial, cremation, or removal, which?)

Date thereof Sept. 1946

Cemetery or crematory.....

Mechanics Cemetery

Location.....

Chincoteague Va

18. Funeral director.....

Address Walter M. Clark

19. (Date rec'd by registrar)

19. (Date rec'd by registrar)

Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Worcester

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

090-03-4077

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

August 28, 1946, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 13 1946, to Aug. 28 1946

and that I last saw her alive on Aug. 28 1946

Immediate cause of death.....

Carcinoma of liver

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Carcinoma of liver

Date of op. Oct. 15-46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

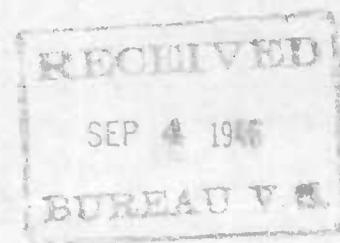
Means of Injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Salisbury, Md. Date signed Oct. 24, 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

08431

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Street No. ....

How long in hospital or institution?

## 3. (a) FULL NAME

Annie Eliza Jones

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George Henry Jones

7. Birth date of deceased (mo., day, yr.)

Jan. 22-1860

6. (c) If alive, give age..... years

8. AGE:

Years 86 Months 6 Days 26 If less than one day hrs. . . . . min. . . . .

9. Birthplace

Allen Md.

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

Alexander Munro

12. Name

Mt. Vernon Md.

13. Birthplace

Allen Md.

14. Maiden name

Price

15. Birthplace

Allen Md.

16. Informant

Mrs. Clarence Hitch

Address

R.O. #1. Salsbury Md.

17. (Burial, cremation, or removal, which?)

Burial Date thereof Aug. 21-46

(month) (day) (year)

Cemetery or crematory

Frontland Farm

Location

Frontland Md.

18. Funeral director

Hillmyer &amp; C. Walter P. Hollings

Address

Salsbury Md.

19. (Date record by registrar)

8/19/46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

80. #1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

Aug 18-46 46, at 8:30

20. DATE OF DEATH

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death Certificate

CORONARY OCCLUSION

Due to CORONARY STENOSIS

Due to

Other conditions HYPERTENSIVE CARDIO-

VASCULAR DISEASE

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature of physician, M. D. or other

Address Date signed 8/19/46

Adm. Dep. Med. Exam.

RECEIVED

AUG 22 1945

BUREAU V S

Evidence for change of year MARYLAND STATE DEPARTMENT OF HEALTH  
of birth of deceased is shown on 2411 N. Charles St., Baltimore 4D

FILM No. I 06 AUG 26 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 999

08432

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

3. (a) FULL NAME

Hester Mae Jones

4. Sex female 5. Color or race A. A. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife no

7. Birth date of deceased (mo., day, yr.) Dec 26 1928 6. (c) If alive, give age no years

8. AGE: Years 17 Months 7 Days 14 If less than one day hrs. min.

9. Birthplace Salisbury md  
(Town, county, and state)

10. Usual occupation School girl

11. Industry or business Dance as above

MOTHER FATHER 12. Name Otha Jones

13. Birthplace Edenree md

14. Maiden name Eda Marshall

15. Birthplace Danes Quarters

16. Informant Eda Jones

Address Salisbury md

17. Burial Burial Date thereof Aug 12 - 1946  
(Burial, cremation, or removal. Which? (month) (day) (year))

Cemetery or crematory Houston

Location Salisbury md

18. Funeral director James H. Stewart

Address Salisbury md

19. Date rec'd by registrar 8/12/46 1946 James H. Stewart Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico

City or town Salisbury md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 402 Gordon St. (If rural, give LOCATION)

2.(a) If veteran, name war no

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946, at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 8 1946, to Aug 11 1946, and that I last saw her alive on Aug 10 1946.

Immediate cause of death:

Congestive Heart Failure

Due to: Rheumatic Heart Disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

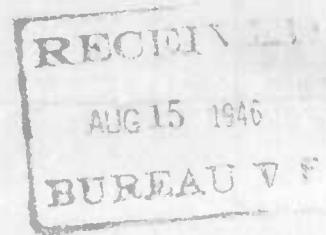
Means of Injury

Injured at work?

23. SIGNATURE John H. James

M. D. or other

Address 238 Linden Ave Date signed Aug 13, 1946 Salisbury



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08433

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County... Wicomico  
City or town... Salisbury and  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? about one hourHospital, institution, or street address where death occurred:  
Peninsula General HospitalHow long in hospital or institution? about one hour

## 3. (a) FULL NAME

Laretta Jones  
4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced SingleB. (b) Name of husband or wife no7. Birth date of deceased (mo., day, yr.) Aug 2 6. (c) If alive, give age 1945 years8. AGE: Years 1 Months 8 Days 12 If less than one day hrs. min.9. Birthplace... Allen and  
(Town, county, and state)10. Usual occupation no11. Industry or business no12. Name Thomas Jones13. Birthplace Florida14. Maiden name Laretta Mae Quince15. Birthplace Florida16. Informant Laretta Mae QuinceAddress Allen and17. Burial Burial Date thereof Aug 16-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WaustonLocation Salisbury and18. Funeral director James H. StewartAddress Salisbury and19. Date recd. by registrar 8/19/46 19. Date of death Aug 16, 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... WicomicoCity or town... Allen and  
(If outside city or town limits, write RURAL and give nearest town)Street No... no  
(If rural, give LOCATION)2.(a) If veteran, name war no3. (b) Social Security Number no

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 46 3.12 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 (2:30 a.m.) 46, Aug 14 3.12 a.m. 19. 46  
and that I last saw her alive on Aug 14 19. 46Immediate cause of death Bronchitis - Pneumonia DURATION UnknownDue to Had been sick several days but unable to get additional informationDue to gastroenteritisOther conditions no

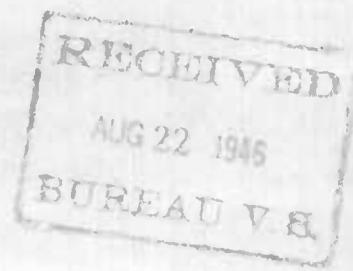
(Include pregnancy within 3 months of death)

Major findings of operations noDate of op. noAutopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of noWhere did injury occur? no (City or town) no (County) no (State)Injured at home, farm, industry, public place (where?) noMeans of injury no Injured at work? no23. SIGNATURE John R. MannM. D. or other noAddress Johnson and Date signed 8/19/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

18434

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Seven days (7)

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Elgin  
Law, Mr. Eddie H. Mario

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhitemarried

## 6. (b) Name of husband or wife

Law, Mrs. Christine

## 7. Birth date of deceased (mo., day, yr.)

Feb. 28, 1883

6. (c) If alive, give age

60

years

## 8. AGE:

Years

Months

Days

If less than one day

61

5

15

hrs.

min.

## 9. Birthplace

STERLING, Illinois

(Town, county and state)

## 10. Usual occupation

Actor

## 11. Industry or business

Elgin

12. Name

Thomas J. Law

## 13. Birthplace

Penn.

## 14. Maiden name

Margie & Chudy

## 15. Birthplace

Penn.

## 16. Informant

Mrs. E. M. Law

## Address

Ocean City Md

## 17. Burial

Burial Date thereof 8/15/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Griswoldian Cem.

## Location

Bethel Md

## 18. Funeral director

Diana A. Brubaker

## Address

Bethel Md

## 19. 8/16-1946

Registrar

(Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WorcesterCity or town... Ocean City (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 6 1946 to August 13 1946and that I last saw him alive on August 13 1946 1946

Immediate cause of death

Acute Coronary Artery Occlusion with infarction 8 daysDue to Coronary Artery DiseaseArteriosclerosis Symptoms 6 years

Due to

Essential Hypertension Symptoms 6 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE David J. Gilmore M.D.Address 101 N. Division Street M. D. or other Aug. 13 1946Address Bethel, Md Date signed Aug. 13 1946

AUG 20 1946

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

08435

## CERTIFICATE OF DEATH

Reg. Dist. No. 3-33

## 1. PLACE OF DEATH:

County..... Wicomico  
 City or town..... Salisbury, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Since 5/24/46

Hospital, institution, or street address where death occurred:

Eastern Shore Tb. SanatoriumHow long in hospital or institution? Since 5/24/46

## 3. (a) FULL NAME

Lewis, Nelson

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife Hattie Thornton Lewis6.(c) If alive, give age 41 years7. Birth date of deceased (mo., day, yr.) Feb. 1, 1905

8. AGE: Years	Months	Days	If less than one day
41	6	5	hrs. min.

9. Birthplace Chincoteague, Va.  
(Town, county, and state)10. Usual occupation Waterman

## 11. Industry or business

12. Name George Washington Lewis13. Birthplace Virginia14. Maiden name Eliza Hall15. Birthplace Virginia16. Informant self

## Address

17. Burial Burial Date thereof Aug 18-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mechanics CemeteryLocation Chincoteague Va18. Funeral director Walter M. BlackAddress Chincoteague Va19. 8/18/46 1946. George S. Debus Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester

City or town Berlin, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 128 S. Main Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

219-14-4432

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 46 1946, at 3:20a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/24/46 1946, to 8/18/46 1946,and that I last saw h. in alive on 8/16/46 1946.

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

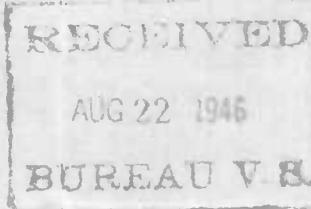
## 23. SIGNATURE

Paul G. Hen W. A.

M. D. or other

Address Sylvia Hill Date signed 8/18/46

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 792

## CERTIFICATE OF DEATH

08430

330

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

St. Louis

City or town.....

Mardela

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

52 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Maggie A. Lowe

4. Sex

F

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

B. (b) Name of husband or wife.....

Levin Lowe

B. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

Jan 11 1866

8. AGE:

Years

Months

Days

If less than one day

80

7

13

hrs. min.

9. Birthplace.....

Mardela, St. Louis, Md.

(Town, county, and state)

10. Usual occupation.....

Housework

11. Industry or business

Samuel R. Windsor

12. Name.....

Samuel R. Windsor

13. Birthplace

Md.

14. Maiden name.....

Elizabeth A. Bailey

15. Birthplace

Md.

16. Informant.....

Mrs. Ella L. Mitchell

Address

Salisbury, Md.

17. Burial

Date thereof.....

(Burial, cremation, or removal, where?)

(month) (day) (year)

Cemetery or crematory

Mardela, Md.

Location

"

18. Funeral director.....

Crawford Bros.

Address

Sharptown, Md.

19. (Date rec'd by registrar)

M. H. Robertson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

St. Louis

City or town.....

Mardela

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 24 1946 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 16 1946 to Aug 24 1946 and that I last saw her alive on Aug 25 1946

Immediate cause of death.....

Pernicious Anemia

DURATION

1 year

Due to.....

Due to.....

Other condition.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work? .....

23. SIGNATURE

H. H. Johnson, M.D.

M. D. or other

Address: Sharptown, Md. Date signed: Aug 27, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Rademaker

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08437

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pennsylvaniia General Hospital

How long in hospital or institution?

8 hrs - 41 Mins.

## 3. (a) FULL NAME

Syndora Johnson Franklin4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced MarriedMale White6. (b) Name of husband or wife Florence Lynch7. Birth date of deceased (mo., day, yr.) Dec. 22, 18968. AGE: Years 49 Months 7 Days 14 If less than one day hrs. 00 min. 009. Birthplace Wicomico Co. Md.

(Town, county, and state)

10. Usual occupation Farmer, carpenter

## 11. Industry or business

12. Name George S. Lynch13. Birthplace Md.14. Maiden name Alvira Ennis

15. Birthplace

16. Informant Florence LynchAddress Whaleyville, Md.17. Burial Date thereof 8/8/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Bethel CemeteryLocation near Whaleyville, Md.18. Funeral director Henry S. WaltonAddress Pocomoke City, Md.19. 8/8/46 (Date rec'd by registrar) 19. 8/8/46 (Date of death) 8/8/46 (Date signed by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty WicomicoCity or town Whaleyville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war 1st world war ✓

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1946, at 12 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical examiner 19 and that I last saw b. alive on 19.

Immediate cause of death

coronary occlusion

DURATION

10 minDue to Fractured femur left  
multiple lacerations of body

4 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8/5/46Where did injury occur? Bethel Cemetery (City or town) Wicomico (County) Md. (State)Injured at home, farm, industry, public place (where?) NegligenceMeans of injury Head - on collision Injured at work? No23. SIGNATURE Dr. Rademaker M.D. or other W.C. JohnsonAddress Salisbury, Md. Date signed 8/8/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

## CERTIFICATE OF DEATH

08438  
Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

Wicomico

City or town

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

39 hrs.

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug. 3-1946

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day  
39 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

## 11. Industry or business

12. Name

Gerald Keith Mach

Antigo, Wis.

MOTHER FATHER

13. Birthplace

Louise Phyllis

14. Maiden name

Salisbury, Maryland

15. Birthplace

Wm. Head of W.K. Mach

16. Informant

Address 308 Naylor St. Salisbury, Md.

17. Burial

Date buried Aug. 16-1946

(Burial, cremation, or removals? Which?)

Cemetery or crematory

Location

Holloway &amp; C. Weller P. Holloway

18. Funeral director

Address

Salisbury, Maryland

19. (Date rec'd by registrar)

19. (Date of death)

8/6/46

Hassett &amp; Johnson

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED!

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

House No.

Apartment No.

Block No.

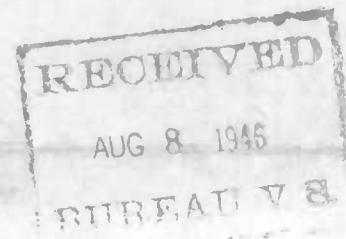
Door No.

Unit No.

Room No.

Floor No.

Unit No.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

08439

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

506 E. Isabella St.

How long in hospital or institution?

## 3. (a) FULL NAME

David Mansell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widower

Anna Mansell

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Feb. 13-1865 Dead

8. AGE:

Years Months Days If less than one day  
81 6 7 hrs. min.

9. Birthplace

(Town, county, and state)

England

10. Usual occupation

Retired Farmer

11. Industry or business

Mansell

12. Name

Mansell

13. Birthplace

England

14. Maiden name

No. Record

15. Birthplace

England

16. Informant

Mr. Arthur Mansell

Address

506 E. Isabella St. Salisbury

17. (Burial, cremation, or removal, which?)

Burial Aug 24-41

Date thereof

(month)

(day)

(year)

Cemetery or crematory

W.C. Mem. Park

Location

Salisbury Maryland

18. Funeral director

H. H. H. &amp; Co. Walter P. H. H.

Address

Salisbury Maryland

19. (Date rec'd by Registrar)

8/24/46

19

8/24/46

8/24/46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

506

E. Isabella St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 20-46

19

st

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw deceased alive on

19

10

Immediate cause of death

choptic myocystis

19

10

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

John P. Mansell M.D.

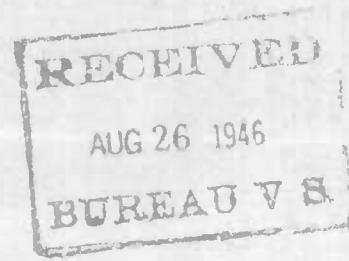
M. D. or other

Signature

Address

Date signed

8/20/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

08440

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

415 Davis St.

How long in hospital or institution?

## 3. (a) FULL NAME

Daniel W. Nelson4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) March 4, 18618. AGE: Years 85 Months 5 Days 7 If less than one day  
..... hrs. ..... min.9. Birthplace Wicomico Co. Md  
(Town, county, and state)10. Usual occupation None

## 11. Industry or business

12. Name Daniel F. Nelson13. Birthplace Wicomico Co. Md14. Maiden name Sarah White15. Birthplace Wicomico Co. Md16. Informant Mr. Bliss NelsonAddress Salisbury, Md17. Burial Burial Date thereof Aug. 14, 1946  
(Burial, cremation, or removal. Which?)Cemetery or crematory Rockawalkin Church CemeteryLocation Rockawalkin, Md18. Funeral director The Hill & Johnson Co.Address Salisbury, Md19. 8/14/46 Harriet E. Johnson Registrar  
(Date record by registrar) Robert J. Gore  
Address Salisbury, Md M. D. or other  
Date signed 8-13-46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1946 19..... 11 30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death Urinary DURATION 3 daysDue to Chronic nephritis. 2

Due to.....

Other conditions old Fracture, right hip. 2  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

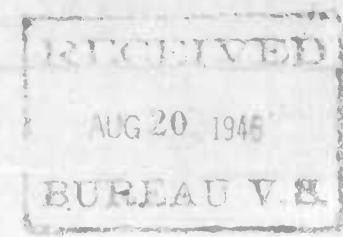
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Robert J. Gore M. D. or otherAddress Salisbury, Md Date signed 8-13-46



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

08441

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

## 1. PLACE OF DEATH:

County Bel AirCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs.

Hospital, institution, or street address where death occurred:

Baltimore, Md.

How long in hospital or Institution?

## 3. (a) FULL NAME

William Ruddy Mutschler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m white widower6. (b) Name of husband or wife mary E. mutschler

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 14, 1877

8. AGE:

Years

Months

Days

If less than one day

68 8 9 hrs. min.

9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation

Brass molder

11. Industry or business

Joseph B. Mutschler18 Albany, GermanyMartha A. RuddyIrelandEladip MutschlerBaltimore, Md.Burial Date thereof 8/24/46

(Burial, cremation, or removal. Which?)

Cemetery or crematory Greenwich CemeteryLocation Greenwich, Conn.18. Funeral director C. G. M. M. Co.Address Baltimore, Md.19. Date rec'd by registrar Aug. 22, 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County Bel AirCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 21<sup>st</sup> 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on August 19 1946

Immediate cause of death

InanitionDue to Generalized CircumscriptiveDue to Carcinoma of Stomach

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

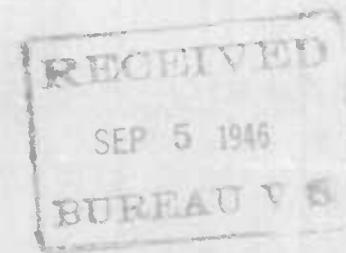
Means of injury

Injured at work?

23. SIGNATURE Robert J. Gore

M. D. or other

Address Hantock, Md. Date signed 8-22-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-142

08442

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days 16 hrs 39 mins

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 9 days 16 hrs 39 mins

## 3. (a) FULL NAME

Nicholson, Mr. Elijah4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Coax. Nicholson7. Birth date of deceased (mo., day, yr.) July 8, 1873 6. (c) If alive, give age 71 years8. AGE: Years 73 Months 1 Days 6 If less than one day hrs. . . . . min. . . . .9. Birthplace Wicomico Co., Md.

(Town, county, and state)

10. Usual occupation Retired Farmer

## 11. Industry or business

12. Name John St. Nicholson13. Birthplace Maryland14. Maiden name Esther Dingers15. Birthplace Maryland16. Informant Mrs. Cox & NicholsonAddress Bellview, Md.17. Burial Date thereof 8/16/146

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory BuckleyLocation Bucks, Md.18. Funeral director The New Jersey Co.Address Salisbury, Md.19. 8/15/46 (Date read by registrar)19. 8/16/46 (Date signed)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Virginia County... WicomicoCity or town Bellview (If outside city or town limits, write RURAL and give nearest town)Street No. ✓

(If rural, give LOCATION)

2.(o) If veteran, name war ✓3. (b) Social Security Number ✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1946 at 5:39 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 14 1946 to Aug 14 1946 and that I last saw him alive on Aug 14 1946

Immediate cause of death

Obesity HypertrophiedDue to Obesity Hypertrophied  
Ch. Myelitis

Due to

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings or operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. H. Web

M. D. or other

Address Salisbury, Md.Date signed 8/16/46

RECEIVED

AUG 20 1946

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

18443

## 1. PLACE OF DEATH:

County. WicomicoCity or town. EdenRural 2

(If outside city or town limits, write RURAL and give nearest town)

60 Years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charlotte A. Pryor4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced WidowedB. (b) Name of husband or wife David A. Pryor7. Birth date of deceased (mo., day, yr.) Dec. 16, 1857 6. (c) If alive, give age years8. AGE: Years 88 Months 7 Days 22 If less than one day hrs. min.9. Birthplace Wicomico, Co. Md.  
(Town, county, and state)10. Usual occupation At Home

## 11. Industry or business

12. Name John Owens13. Birthplace Wicomico, Co. Md.14. Maiden name Dennis15. Birthplace Worcester Co. Md.16. Informant Mrs. James PalmerAddress Fruitland, Md17. Burial Burial Date thereof Aug. 9, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wicomico Memorial ParkLocation Salisbury, Md18. Funeral director The Hill & Johnson Co.Address Salisbury, Md19. 8/16/46 (Date received by registrar)Signature Chas. L. Johnson Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town Eden Rural 2

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7, 1946 19 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-20- 1946 to 8-7- 1946and that I last saw her alive on 7-30- 1946

Immediate cause of death

acute Right heart failureDue to Sensitivity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE Chas. L. Johnson

M. D. or other

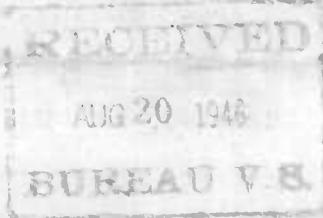
Address \_\_\_\_\_

Date signed 5-9-46

Mark 4,

85 -

22  
46  
68



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

08444

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

O.Y. Hospital

How long in hospital or institution?.....

## 3. (a) FULL NAME

Baby Russell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

brown

single

6. (b) Name of husband or wife.....

6. (c) It alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

August

12-1946

8. AGE:

Years

Months

Days

It less than one day

1

2

hrs.

min.

9. Birthplace.....

Pocomoke City, Worcester, Md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER

Robert Waters

13. Birthplace

Maryland

MOTHER

Margaret Russell

15. Birthplace

Maryland

16. Informant.....

Pauline Russell

Address

Pocomoke City, Md Rural #2

17. Burial

Cremation

Date thereof..... Aug 14 46

(month) (day) (year)

Cemetery or crematory.....

Johnson Neck

Location.....

Pocomoke City, Md

18. Funeral director.....

Clay O. Dennis

Address.....

Snow Hill, Md

19. (Date read by Registrar)

8/14/46

19. (Date read by Registrar)

Barrett S. Johnson

Address.....

Snow Hill, Md

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Worcester

City or town..... Pocomoke City, Rural #2

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

370

## 3. (b) Social Security Number

7001

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

August 14 1946 at 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 12 1946, to Aug 14 1946

and that I last saw him alive on Aug 13 1946

Immediate cause of death.....

Respiration paralysis

Due to.....

Prematurity  
(2 mos gestation)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

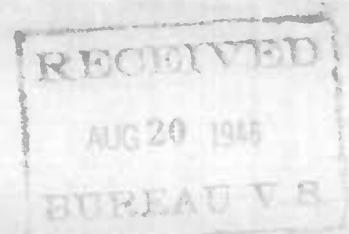
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08446

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

36 years

Hospital, institution, or street address where death occurred:

R.D. #2

How long in hospital or institution?

## 3. (a) FULL NAME

Lewis Phillips Reity

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Martha E. Reity

7. Birth date of deceased (mo., day, yr.)

deceased (mo., day, yr.)

Jan. 19-1856

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

Baltimore Maryland

(Town, county, and state)

10. Usual occupation

Retired on Farm

11. Industry or business

Formerly Glass Blower

12. Name

George Frederick Reity

13. Birthplace

Germany

14. Maiden name

Mary Ann Early

15. Birthplace

New Jersey

16. Informant

Mrs. Martha E. Reity

Address

R.D. #2, Salisbury Maryland

17. Burial

Date thereof Aug. 21-46

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Charity Church Cem.

Location

R.D. #2, Salisbury Md.

18. Funeral director

Holloway &amp; Co. Walter R. Holloway

Address

Salisbury Maryland

19. (Date rec'd by registrar)

Aug. 13, 1946, Telecast by Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

Street No.

R.D. #2

1. (If outside city or town limits, write RURAL and give nearest town)

2. (If rural, give LOCATION)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 1st 1946 at 462409

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 14 1946 to July 30 1946

and that I last saw her alive on July 30 1946

Immediate cause of death

Arterio sclerosis

Due to

Due to

Other conditions

Arterio sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Name of injury Injured at work

23. SIGNATURE

William E. Guire

M. D. Other

Address Johnson &amp; Elmer, Md. Date signed Aug. 2-46

RECEIVED

AUG 8 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

08445

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Saint Michaels

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days - 10 hrs.

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 3 days 10 hrs

## 3. (a) FULL NAME

Roach, Mr. Andrew William4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Sally Roach

7. Birth date of deceased (mo., day, yr.)

April 2, 18846. (c) If alive, give age 49 years8. AGE: Years 62Months 3Days 29

If less than one day

hrs.  min. 9. Birthplace Berlin

(Town, county, and state)

10. Usual occupation merchant

11. Industry or business

William Roach12. Name William Roach13. Birthplace Pa.14. Maiden name Annie Messmer15. Birthplace Pottstown, Pa.16. Informant Mrs. Andrew RoachAddress Berlin MD17. Burial Burial Date thereof 8/3/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory EvergreenLocation Berlin MD18. Funeral director Drama R. BullockAddress Berlin MD19. 8/3/46 (Date rec'd by registrar) Harriett S. Sall (Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty WicomicoCity or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. 

(If rural, give LOCATION)

2.(a) If veteran, name war 

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1946 at 2:05 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1946 to August 1, 1946 and that I last saw him alive on August 1, 1946Immediate cause of death Acute Coronary artery occlusion with myocardial infarction  
Due to Arteriosclerosis of Coronary arteries DURATION 6 days  
Symptoms 6 mos.Due to Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

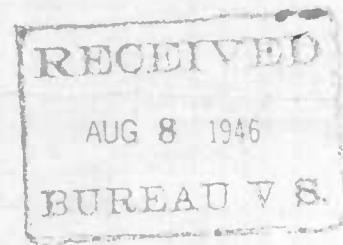
Accident, suicide, or homicide —Date of Where did injury occur? (City or town)(County) (State) Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —

23. SIGNATURE

David J. Gilmore M.D.

M. D. or other

Address Johns Hopkins Hospital, Baltimore, Md.Date signed Aug 1, 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

158

## CERTIFICATE OF DEATH

18447-9-29  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days - 16 hours

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 2 days - 16 hours

## 3. (a) FULL NAME

Schoolfield, Rosalie

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female colored single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

July 5-1946

8. AGE:

Years

Months

Days

If less than one day

28 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19. (Date signed)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WicomicoCity or town... Rural Poocomoke (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1946 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 31 1946 to Aug 2 1946and that I last saw her alive on Aug 2 1946

Immediate cause of death

malnutrition

DURATION

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

LaPademah M.D. M. D. or otherAddress... Johns Hopkins, Md. Date signed 8/3/46

RECEIVED

AUG 8 1946

BUREAU F B I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore, Md.

08448

## CERTIFICATE OF DEATH

Reg. Dist. No. 64 330

## 1. PLACE OF DEATH:

County WicomicoCity or town Mandela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Harvey C. Thomas

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Barbara Thomas

7. Birth date of deceased (mo., day, yr.)

March 24, 1912

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years  
34Months  
5Days  
3If less than one day  
hrs. min.

9. Birthplace

Sussex County, Delaware

(Town, county, and state)

10. Usual occupation

Day Laborer

11. Industry or business

Farm

FATHER

12. Name Frederick Thomas

MOTHER

13. Birthplace Wicomico County, Maryland14. Maiden name Edna Hopkins15. Birthplace Wicomico County, Maryland16. Informant Mrs. Edna ThomasAddress Mandela Springs, Maryland, P.T.D.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof August 29, 1946  
(month) (day) (year)Cemetery or crematory Mandela Methodist CemeteryLocation Mandela Springs, Maryland, P.T.D.18. Funeral director J. J. Frampton and SonAddress Federalsburg, Maryland

19. August 29

19 46

S. J. Frampton  
Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty WicomicoCity or town Mandela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

215-26-4166

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1946 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

bed and gave respiration 19and that I last saw him alive on 19

Immediate cause of death

Coronary Occlusion

DURATION

udden death

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations No

Date of op.

No

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

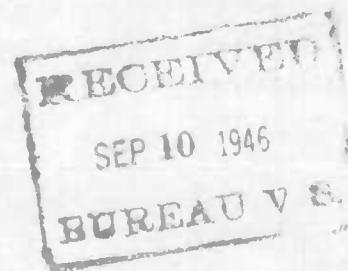
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE S. J. Frampton M. D. or otherAddress S. J. Frampton, M.D. Date signed 8/26/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08441

## CERTIFICATE OF DEATH

Reg. Dist. No. 339

## 1. PLACE OF DEATH:

County..... **Wicomico**City or town..... **Salisbury**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **12 years**

Hospital, Institution, or street address where death occurred:

..... **Peninsula General Hospital**How long in hospital or institution? **5 days**

## 3. (a) FULL NAME

**Jasper Lee White**4. Sex **male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **married**6. (b) Name of husband or wife **Mattie M. White**7. Birth date of deceased (mo. day. yr.) **Nov. 24, 1882**8. AGE: Years **63** Months **8** Days **23** If less than one day hrs. .... min. ....9. Birthplace **Wicomico Co. Md.**  
(Town, county, and state)10. Usual occupation **Farmer**

## 11. Industry or business

12. Name **Thomas H. White**13. Birthplace **Wicomico Co. Md**14. Maiden name **Mary E. Harris**15. Birthplace **Wicomico Co. Md**16. Informant **Mrs. Jasper L. White**Address **Fruitland, Md**17. Burial **Burial** Date thereof **Aug. 18, 1946**  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory **Siloam Cemetery**Location **Siloam, Md**18. Funeral director **The Hill & Johnson Co.**Address **Salisbury, Md**19. **8/26/46** (Date rec'd by registrar) **Harrington Johnson** (Signature)  
Address **238 Camden Ave.** **Salisbury, Md.** Date signed **Aug. 16, 1946**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Md** County **Wicomico**City or town **Fruitland**

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 16, 1946** 19..... 7 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**May 10, 1946** to **Aug. 16, 1946**, and that I last saw him alive on **Aug. 16, 1946**.

Immediate cause of death

**Angina Pectoris**

DURATION

Due to **Arteriosclerosis**

?

Due to.....

?

Other conditions.....

?

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

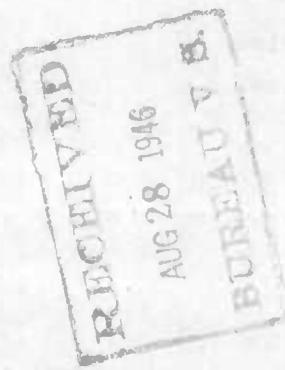
Means of Injury

Injured at work?

23. SIGNATURE **John H. Jeanner M.D.**

M. D. or other

Address **238 Camden Ave.**Date signed **Aug. 16, 1946**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

08450

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. .... min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal? Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date read by registrar)

(Signature) Registrar.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

Aug. 18<sup>th</sup> 46 7. a21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 1, 1946, to day of death, 1946,  
and that I last saw him alive on Aug. 17, 1946.

Immediate cause of death.....

Hypertension, chronic

DURATION

2 yrs.

Due to.....

Due to.....

Other conditions.....

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury.....

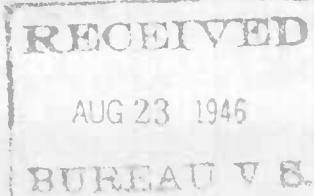
Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed 8/19/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08451

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Saboty M.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days - 7 hrs. 40 min.

Hospital, institution, or street address where death occurred:

Peninsula General Hospital10 days 7 hrs - 40 min

How long in hospital or institution?

## 3. (a) FULL NAME

Williamson, Mr. John Thomas

4. Sex

5. Color or race

(a) Single, married, widowed, or divorced

male

white

married

## 6. (b) Name of husband or wife

Marie Maud Williamson(b) If alive, give age 35 years

## 7. Birth date of deceased (mo., day, yr.)

Feb. 24, 1906

## 8. AGE:

Years 40Months 5Days 19

If less than one day

hrs. ..... min. .....

## 9. Birthplace

Bridgewater Delaware

(Town, county, and state)

## 10. Usual occupation

Operator ofPetroleum

## 11. Industry or business

John Mitchell Williamson

12. Name

MOTHER

FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Burial

Cremation

Removal

Which?

Date thereof

(month)

(day)

(year)

Location

Cemetery or crematory

Name

of

Burial

Cremation

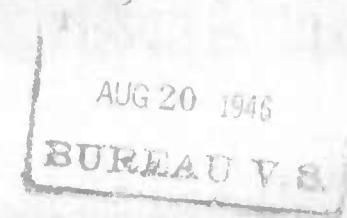
or removal

Which?

Date

signed

Date



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08452

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 2 hours

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? About 2 hours

## 3. (a) FULL NAME

Stanley Wales Wilson4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) February 22, 19278. AGE: Years 19 Months 5 Days 19 If less than one day — hrs. — min.9. Birthplace Princess Anne, Maryland  
(Town, county, and state)10. Usual occupation Mechanic11. Industry or business Garage12. Name Oscar Edward Wilson13. Birthplace Oriole, Maryland14. Maiden name Mita Grace Hosca15. Birthplace Salisbury, Maryland16. Informant Shirley M. WilsonAddress Princess Anne, Maryland17. Burial Burial Date thereof Aug. 11, 1946  
(Burial, cremation, or removal. Which?)Cemetery or crematory St. Andrew's CemeteryLocation Princess Anne, Maryland18. Funeral director Charles M. DashielAddress Princess Anne, Md.19. 8/16/1946 19. 8/16/1946 Death certificate Death certificate(Date rec'd by registrar) 8/16/1946 Death certificate Death certificate20. 8/16/1946 Death certificate Death certificate(Date signed) 8/16/1946 Death certificate Death certificate21. 8/16/1946 Death certificate Death certificate(Date signed) 8/16/1946 Death certificate Death certificate

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty SomersetCity or town Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 46 at 2:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 46 at 10 A.M.Immediate cause of death Crushed skull broken neck DURATIONDue to —Due to —Other conditions —

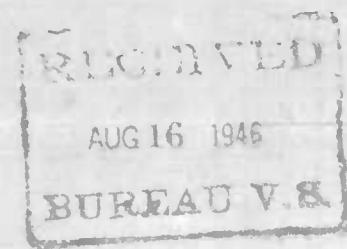
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide Accident Date 8/10/46Where did injury occur? near Princess Anne, Somerset, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of injury Auto accident Injured at work? No23. SIGNATURE Henry M. Lambford, M.D. M. D. or otherAddress Princess Anne, Md. Date signed 8/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 329

## 1. PLACE OF DEATH:

Wicomico County.....

Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Since 7/8/46

Hospital, institution, or street address where death occurred:

Eastern Shore Tuberculosis Sanatorium

How long in hospital or institution?..... Since 7/8/46

## 3. (a) FULL NAME

Winterbottom, James Harrison

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1878 6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day 67 10 16 hrs. min.

9. Birthplace Royal Oak, Maryland (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name James Thomas Winterbottom

13. Birthplace Talbot County, Maryland

14. Maiden name Hattie Canik

15. Birthplace Baltimore, Maryland

16. Informant S.A.F.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 24, 1946

(month) (day) (year)

Cemetery or crematory Spring Field Cemetery

Location Easton, Md.

18. Funeral director Maurice E. Neenan, Son

Address Easton, Maryland

19. 9/24/46 1946 Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town R.F.D. Easton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war No

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

2D. DATE OF DEATH AUGUST 30 1946 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 8 1946 to Aug. 30 1946

and that I last saw him alive on Aug. 30 1946

Immediate cause of death

For advanced Pulmonary Tuberculosis

DURATION

14 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul Ober

M. D. or other

Snow Hill, Maryland Date signed 8/31/46

